PROXY IDENTIFICATION VERIFICATION FOR ACCESS TO BON SECOURS MYCHART

TO BE COMPLETED BY PATIENT:

Please Print

First Name_____ Last Name_____ MI_____

Date of Birth_____ Patient Member ID Number_____ E-Mail Address_ Physician _____

_____

Name of Designated Proxy _____
(First) (MI) (Last)

Designated Proxy Mailing Address _____
(Street Address/P.O. Box) (City) (State) (Zip Code)

TO BE COMPLETED BY PROXY:

Please Print

First Name_____ Last Name_____ MI_____

Date of Birth_____ Social Security Number_____ E-Mail Address_____

HOW MYCHART WORKS

Bon Secours Health System, Inc., and its controlled affiliates that operate one or more hospitals or physician practices located in Florida, Kentucky, Maryland, New York, South Carolina or Virginia ("Bon Secours") provide a secure web site known as MyChart to allow you to access some (but not all) of your confidential health information contained in your Bon Secours electronic medical record ("EMR"), to the extent you have a Bon Secours EMR. MyChart is not your complete EMR. In addition, MyChart sometimes shows a summary or description and not the actual entries in your EMR.

You can access MyChart by logging into the web site (https://mychart.bonsecours.com/mychart/) with a special identification code. In order to obtain the identification code, you must complete this IDENTIFICATION VERIFICATION FOR ACCESS TO MYCHART REQUEST, and must accept and agree to comply with the MYCHART ACCESS RESPONSIBILITIES set forth below. You will then be mailed a special identification code and instructions for activating your MyChart account and establishing a unique User ID and Password. When you first activate your MyChart account, you will also be required to read and agreed to comply with the MYCHART TERMS AND CONDITIONS OF PATIENT USE. You will also be required to read and agree to the PROXY DISCLAIMER each time you access MyChart.

PROXY IDENTIFICATION VERIFICATION INSTRUCTIONS

You must provide the information requested above and sign the Acknowledgement. Your signature *must* be verified by a notary public. Be prepared to present one of the following current identification documents: (1) your driver's license or government-issued ID card with your photograph; (2) your valid passport; or (3) your picture ID and U.S. Social Security card.

PROXY ACKNOWLEDGEMENT

I hereby acknowledge that the above information, including my name, e-mail address, date of birth, Social Security Number, and mailing address is true and correct.

Signature_____ Date _____

Print Name _____

PROXY IDENTIFICATION VERIFICATION

Identification Document:

☐ Driver's License/Government Issued ID ☐ Passport ☐ Picture ID & Social Security Card

Identification Document Number_____ Expiration Date _____

NOTARY SIGNATURE

State of_____, County/City of _____

I certify, based on personal knowledge or based on satisfactory evidence, which was (document name/type) _____ (number) _____ (expiration date) _____, that (person's name)_____ is the person who appeared before me, and said person acknowledged that he/she signed this instrument and acknowledged it to be his/her free and voluntary act for the uses and purposes mentioned in this instrument.

Notary Public Signature (seal or stamp) **Date**

Title **Date my appointment expires**

After verification by notary public, mail form to your Physician Practice: